

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

☒ The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

☒ The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

☐ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

☐ The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.

Specify the division/unit name:
Department of Developmental Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

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2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Department of Social Services (DSS) and Department of Developmental Services (DDS) utilize a Memorandum of Understanding to identify assigned waiver operational and administrative functions in accordance with waiver requirements. DSS is the single state Medicaid agency responsible for the overall administration of the HCBS Waiver and assuring that federal reporting and procedural requirements are satisfied. In carrying out these responsibilities, DSS performs the following functions:

1. Coordinates communication with federal officials concerning the waiver; Specifies and approves policies and procedures and consults with DDS in the implementation of such policies and procedures, that are necessary and appropriate for the administration and operation of the waiver in accordance with federal regulations and guidance;
2. Monitors waiver operations for compliance with federal regulations including, but not limited to, the areas of waiver eligibility determinations, service quality systems, plans of care, qualification of providers, and fiscal controls and accountability;
3. Determines Medicaid eligibility for potential waiver recipients/enrollee;
4. Establishes, in consultation and cooperation with DDS, the rates of reimbursement for services provided under the waiver;
5. Assists with the billing process for waiver services, completes billing process and claims for FFP for such services;
6. Prepares and submits, with assistance from DDS, all reports required by CMS or other federal agencies regarding the waiver; and,
7. Administers the hearing process through which an individual may request a reconsideration of any decisions that affect eligibility or the denial of waiver services as provided under federal law.

As the operating agency,

DDS is responsible for the following components of the program:

1. Conducts initial assessments and required re-assessments of potential waiver enrollees/recipients using uniform assessment instrument(s), documentation and procedure to establish whether an individual meets all eligibility criteria including that set forth as part of the evaluation and criteria in 42 CFR Sec. 441.302;
2. Documents individual plans of care for waiver recipients in format(s) approved by DSS, which set forth: (1) individual service needs, (2) waiver services necessary to meet such needs, (3) the authorized service provider(s), and (4) the amount of waiver services authorized for the individual;
3. Establishes and maintains quality assurance and improvement systems designed to assure the ongoing recruitment of qualified providers of waiver services and documents adherence to all applicable state and federal laws and regulations pertaining to health and welfare consistent with the assurance made in the approved waiver application(s);
4. Develops and amends as necessary, training materials, activities, and initiatives sufficient to provide relevant DDS staff, waiver recipients, and potential waiver recipients, information and instruction related to participation in the waiver program;
5. Maintains and enhances, as necessary, a billing system which: a.) Identifies the source documents that providers use to verify service delivery in accordance with individual plans of care; b.) Assures that the data elements required by CMS for Federal Financial Participation (FFP) are collected and maintained at the time of service delivery; c.) Provides computerized billing system(s) with audit capacity to identify problems and permit timely resolution; and d.) Issues complete and accurate billing information and data to DSS in accordance with the schedules mutually established by the departments;
6. Maintains service delivery records in sufficient detail to assure that waiver services provided were authorized by individual plans of care and delivered by qualified providers in accordance with the waiver(s);
7. Provides ongoing support and performs periodic audit and assessment of providers of waiver services;
8. Establishes and maintains a person-centered component to the evaluation and improvement activities

associated with waiver services;

9. Establishes, maintains and documents the delivery of "case management" and "broker" services as indicated in the individual plan of care;

10. Establishes and maintains a system that provides for continuous monitoring of the provision of waiver services to assure compliance with applicable health and welfare standards and evaluates individual outcomes and satisfaction;

11. Approves the waiver services and settings in which such services are provided;

12. Provides payment for such services from the annual budget allocation to DDS;

13. Assists DSS in establishing and maintaining rates of reimbursement for waiver services;

14. Assists DSS in the preparation of all waiver-related reports and communications with CMS; and,

15. Consults with DSS regarding all waiver-related activities and initiatives including, but not limited to, waiver applications and waiver amendments. DSS receives quarterly reports from DDS as outlined in Appendix H (Quality Management) and meets with DDS on a quarterly basis to review key operating agency activities. DSS meets with DDS on an as needed basis to review individual or systemic issues as they arise. DSS prepares the annual 372 reports.

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3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

☒ Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

MMIS system operated through a contract between DSS and EDS. DDS contracts with Fiscal Intermediaries to support individuals who serve as the employer of record, and to process invoices and makes payment for services for DDS.

☐ No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

☒ Not applicable

☐ Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

☐ Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

	<div>▲</div> <div>▼</div>
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☐ Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

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5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Department of Developmental Services

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6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
1. The DDS Fiscal Intermediaries are monitored by DDS per the terms of the contract. This includes quarterly meeting with DDS, maintenance of a complaint log by DDS, an audit of the organization as a whole by a licensed independent certified public accountant and submitted to the Department annually, with agreed upon procedures for the management of the DDS funds under the control of the fiscal intermediary.
 2. The fiscal intermediary is subject to audit by the Department, agents of the Department, and the State of Connecticut's Auditors of Public Accounts. Records must be made available in CT for the audit.
 3. A copy of the most recent financial statement, with an opinion letter from a CPA with a CT license or by a CPA in the state the vendor performs business in, is required as a part of the RFP proposal.
 4. Fiscal Intermediaries must submit a cost report as requested for rate analysis.

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7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Utilization management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

DSS meets with DDS to evaluate DDS summary reports related to service planning and delivery, provider qualifications, safeguards, fiscal integrity and consumer satisfaction and monitor compliance with the Interagency Agreement.

Data Source (Select one):

Meeting minutes

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Issue specific data
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

DSS conducts the Fair Hearing process and provides instruction to DDS on the implementation of waiver policies. Number of hearings held and decisions made.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Hearing decisions

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100 % Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

DSS conducts random record reviews annually to evaluate Level of Care and Plan of Care requirements. Number and percent of records reviewed by DSS that met the LOC and POC requirements.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Random reviews of 15-30 records annually
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Individual participant issues requiring remediation will be referred back to the person responsible and will be corrected on an ongoing basis. Systemic issues needing remediation will be identified and discussed at the quarterly meetings with DDS and DSS staff. A plan for remediation and person(s) responsible will be developed for each item identified. Remediation strategies and progress towards correction will be reviewed and documented at the next quarterly meeting.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility**B-1: Specification of the Waiver Target Group(s)**

- a. **Target Group(s).** Under the waiver of Section 902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> Aged or Disabled, or Both - General					

<input type="checkbox"/>	Aged			<input checked="" type="checkbox"/>
<input type="checkbox"/>	Disabled (Physical)			
<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups				
<input type="checkbox"/>	Brain Injury			<input checked="" type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input checked="" type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input checked="" type="checkbox"/>
<input type="checkbox"/>	Technology Dependent			<input checked="" type="checkbox"/>
<input checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both				
<input type="checkbox"/>	Autism			<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Developmental Disability	18		<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Mental Retardation	3		<input checked="" type="checkbox"/>
<input type="radio"/> Mental Illness				
<input type="checkbox"/>	Mental Illness			
<input type="checkbox"/>	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Mental Retardation as defined by Con Gen Stat Sec 17a-210. Also included are those determined eligible for DDS services as a result of a hearing conducted by DDS according to the Uniform Administrative Procedures Act or administrative determination of the Commissioner.

Developmental Disability as a target group is limited to individuals who are developmentally disabled who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

Children with significant medical needs who would require institutionalization without waiver services, adults who reside in the family home or adults who do not require 24/7 services in order to remain in their own homes. These individuals have significant natural supports, generic community services and/or state plan services available to them in addition to the services available under this waiver.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

☒ Not applicable. There is no maximum age limit

☐ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and

community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☐ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

- ☐ **Other**

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

Individuals are placed on this waiver based on assessed need. If needs exceed the cost limit of \$28,000 the individual would not be placed on this waiver.

The cost limit specified by the State is (*select one*):

- ☐ **The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

- ☐ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

Increases or decreases in funding allocations as approved by the CT legislature. Adjustments might include items such as; Cost of Living Adjustments (COLA) for service providers or decrease to the DDS budget allocations.

- ☐ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- ☐ The following percentage that is less than 100 % of the institutional average:

Specify percent:

- ☐ Other:

Specify:

	<input type="text"/> <input type="text"/>
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Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

- b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Prospective funding allocations are based on the individual's assessed level of need using the CT Level of Need Assessment and Screening Tool. The team submits a request for services to the Regional Planning and Allocation Team. Based on the findings of the LON Assessment, the PRAT notifies the team of the funding allocations. The team initiates the Individual Planning process in advance of enrollment in a DDS waiver. If the team determines that the initial allocation is insufficient to meet the individual's needs, the team submits a request for utilization review to the PRAT for consideration. The PRAT determines if a higher funding amount is justified and if the funding amount falls within the overall limits of the Employment and Day Supports (EDS) waiver. If approved, the participant will complete enrollment in the Employment and Day Supports waiver and the Individual budget is reviewed and authorizations to initiate services are processed. If the PRAT does not approve the higher funding request, the individual is provided opportunity to informally negotiate a resolution and is simultaneously notified of his/her fair hearing rights as a result of being denied enrollment in the DDS Employment and Day Supports waiver. If the PRAT agrees the individual requires higher funding than is permitted in the Employment and Day Supports waiver prior to enrollment, the PRAT will consider the individual for eligibility in either the DDS Individual and Family Support waiver or the DDS Comprehensive Support waiver following the DDS priority assignment procedures in the management of the DDS waiting list.

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☒ The participant is referred to another waiver that can accommodate the individual's needs.
- ☒ Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

The case manager submits to the PRAT a request for additional services/funding and an updated Level of Need Assessment supporting the request. The PRAT may authorize funding up to the amount associated with the participant's newly determined Level of Need. If the request exceeds the overall limit of the Employment and Day Supports (EDS) Waiver, the PRAT may authorize funding up to \$5,000 more than the EDS waiver limit on a non-annualized basis to meet the participant's immediate needs while other alternatives are coordinated or to meet emergency needs that are not expected to be long-term (i.e. enhanced supports due acute medical needs of the participant, or a temporary change in the capacity of natural supports).

- ☐ Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	200
Year 2	300
Year 3	400

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- ☒ The State does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	

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B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ☐ Not applicable. The state does not reserve capacity.
- ☒ The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes
High School Graduates

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (2 of 4)**

Purpose (*provide a title or short description to use for lookup*):

High School Graduates

Purpose (*describe*):

Individuals who are graduating from high school and who will require employment or day supports.

Describe how the amount of reserved capacity was determined:

Historical data on the number of high school graduates whose assessed Level of Need indicates that their needs can be met with the funding level and range of services available in this waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	75
Year 2	75
Year 3	75

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (3 of 4)**

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
 - ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. **Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

The State DDS uses a priority system to select individuals for entrance to the DDS waivers. The DDS utilizes a Priority Checklist that incorporates findings from the Level of Needs Assessment and Risk Screening Tool and collects findings on additional questions pertaining to individual and caregiver status. The system assigns either an Emergency, Priority 1 or Planning status as a result of the screening tools. Those identified as an Emergency are given first priority to the appropriate waiver program when slots are available. The Priority 1 group is afforded the next priority. Those with elderly caregivers (age 65 and above) are given priority within the Priority 1 sub-set. Beyond the reserved capacity, emergency status and those with elderly caregivers, applicants are managed on a first come, first serve basis. Individuals who are dissatisfied with priority assignment may request in writing to the Commissioner of DDS an administrative hearing pursuant to sub-section (e), section 17a-210, G.S., or, may initiate an informal dispute resolution process, Programmatic Administrative Review (PAR) set forth in DMR Policy 7 (1986). Individuals who request a PAR may also request a Fair Hearing at any time.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. State Classification. The State is a (*select one*):

- ☐ §1634 State
☐ SSI Criteria State
☒ 209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*):

- ☒ No
☐ Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ Low income families with children as provided in §1931 of the Act
☐ SSI recipients
☒ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☒ Optional State supplement recipients
☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☐ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☒ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

- ☒ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Persons defined as severely impaired individuals in section 1619(b) and 1905(q) of the Social Security Act

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- ☐ No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*
- ☒ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

- ☒ A special income level equal to:

Select one:

- ☒ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- ☐ A dollar amount which is lower than 300%.

Specify dollar amount:

- ☒ Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- ☐ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- ☐ Medically needy without spend down in 209(b) States (42 CFR §435.330)
- ☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

- ☒ Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

- ☐ Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-c (209b State) and Item B-5-d)
- ☐ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)
- ☒ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

- b. **Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

☒ The following standard included under the State plan

(*select one*):

☐ The following standard under 42 CFR §435.121

Specify:

	▲ ▼
--	--------

☐ Optional State supplement standard

☐ Medically needy income standard

☒ The special income level for institutionalized persons

(*select one*):

☒ 300% of the SSI Federal Benefit Rate (FBR)

☐ A percentage of the FBR, which is less than 300%

Specify percentage:

☐ A dollar amount which is less than 300%.

Specify dollar amount:

☐ A percentage of the Federal poverty level

Specify percentage:

☐ Other standard included under the State Plan

Specify:

	▲ ▼
--	--------

☐ The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

☐ The following formula is used to determine the needs allowance:

Specify:

	▲ ▼
--	--------

☐ Other

Specify:

	▲ ▼
--	--------

ii. Allowance for the spouse only (*select one*):

☒ Not Applicable (see instructions)

☐ The following standard under 42 CFR §435.121

Specify:

	▲ ▼
--	--------

☐ Optional State supplement standard

☐ Medically needy income standard

☐ The following dollar amount:

Specify dollar amount:

--

 If this amount changes, this item will be revised.

☐ The amount is determined using the following formula:

Specify:

	▲ ▼
--	--------

iii. Allowance for the family (*select one*):

☒ Not Applicable (see instructions)

☐ AFDC need standard

☐ Medically needy income standard

☐ The following dollar amount:

Specify dollar amount:

--

 The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

☐ The amount is determined using the following formula:

Specify:

	▲ ▼
--	--------

☐ Other

Specify:

	▲ ▼
--	--------

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party,

specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☒ Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ The State does not establish reasonable limits.
- ☐ The State establishes the following reasonable limits

Specify:

	<input type="button" value="↑"/> <input type="button" value="↓"/>
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Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

- i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

- ii. **Frequency of services.** The State requires (select one):

- ☒ The provision of waiver services at least monthly

- ☐ Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ☐ Directly by the Medicaid agency
☒ By the operating agency specified in Appendix A
☐ By an entity under contract with the Medicaid agency.

Specify the entity:

- ☐ Other
Specify:

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Case managers, CM Supervisors or other DDS Managers or clinicians who meet the following QMRP standards:

An individual who has received: at least a bachelor's degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a major or minor coursework concentration in a human services field. "Human services field" includes all any academic disciplines associated with the study of: human behavior (e.g., psychology, sociology, speech communication, gerontology etc.), human skill development (e.g., education, counseling, human development), humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g., rehabilitation counseling), or the human condition (e.g., literature, the arts) and who has demonstrated competency to do the job.

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

There is reasonable indication that the person, but for the provision of waiver services would require placement in an ICF/MR. The person requires assistance due to one or more of the following:

1. Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative support in performing self-care and daily activities.
2. Has a deficit in self-care and daily living skills requiring habilitative training.
3. Has a maladaptive social and/or interpersonal patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training.

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is be used to validate the participant's Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/MR Level of Care. The scoring algorithm used to

calculate the Composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- ☒ The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
 - ☐ A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

This determination is made through a planning and support team process utilizing the CT Level of Need Assessment and Screening Tool (LON). Development of the LON was funded through a CMS Systems Change Grant. The LON is a comprehensive assessment of an individual's level of support needs and identification of risk areas in the following domains: Health/Medical, PICA, Behavior, Psychiatric, Criminal/Sexual, Seizure, Mobility, Safety, Comprehension and Understanding, Social Life, Communication, Personal Care, and Daily Living. The Composite Score on the CT LON is used to validate the participant's Level of Care. A Composite score of 1 or greater on this tool is required in order to show that the participant requires an ICF/MR Level of Care. The scoring algorithm used to calculate the Composite score incorporates the scores from the domains listed above and results in an overall score ranging from 1 to 8. The DDS case manager with the Individual Support Team completes the initial, or reviews the existing, CT LON assessment and makes updates as required by changes in the individual. The score on the CT LON determines whether or not the participant meets, or continues to meet, the ICF/MR Level of Care.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- ☐ Every three months
 - ☐ Every six months
 - ☒ Every twelve months
 - ☐ Other schedule
- Specify the other schedule:*

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- ☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
 - ☐ The qualifications are different.
- Specify the qualifications:*

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The CT automated consumer information system (CAMRIS) maintains the date of the last Individual Annual Plan review. The Level of Care determination is completed at the time of each review. The case manager and case manager supervisor use this system as a tickler system.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3

years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All evaluations and re-evaluations are available in the DDS web-based application for the Level of Need Assessment. LOC evaluations and re-evaluations are available in the DDS case management record. The initial evaluations are also maintained in the individual's DSS records.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

- a. *Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new enrollees who had a LOC indicating a need for ICF/MR prior to receipt of services.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100 % Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input type="checkbox"/>	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of LOC determinations that are reevaluated annually.

Data Source (Select one):

Other

If 'Other' is selected, specify:
electronic participant records

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percentage of initial Level of Care determinations that have been verified by a QMRP qualified staff.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div> <input type="button" value="Up"/> <input type="button" value="Down"/> </div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div> <input type="button" value="Up"/> <input type="button" value="Down"/> </div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The CO Waiver Policy and Enrollment Unit notifies the Regional Case Management Supervisor of findings from individual initial enrollment reviews and record audits. Corrective actions are completed in the Regional Offices and reported back to the CO Waiver Policy and Enrollment Unit.

The Case Manager Supervisor ensures remediation of any individual or case manager specific issues identified in the LOC determination review.

- ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. *informed of any feasible alternatives under the waiver; and*
 - ii. *given the choice of either institutional or home and community-based services.*
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals seeking services from DDS are notified of the alternatives available under the waiver and are informed of their option to choose institutional or waiver services by the DDS case manager. This decision is documented on Form 222, Service Selection Form. The State provides individuals with the HCBS waiver Fact Sheet, and with the Guide to Understanding the DDS HCBS Waivers for Individuals and Families at the annual planning meeting, and both are available on the DDS web site.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

DDS case management record and DSS record.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State DDS prepares HCBS waiver informational materials in English and Spanish and posts both to the DDS web site. Additionally, the DDS utilizes a Language Line service to ensure that all individuals who call the DDS at the Central Office or Regional locations will have language interpreter service immediately upon the call. DDS policy states that

language interpretation service will be provided free of charge at all intake, formal planning meetings, hearings or informal dispute resolution process sessions. Once enrolled in an HCBS waiver, interpreter services are also included as a covered waiver service for other purposes as detailed in the plan.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Community Based Day Support Options
Statutory Service	Respite
Statutory Service	Supported Employment
Supports for Participant Direction	Independent Support Broker
Other Service	Behavioral Support Services
Other Service	Individual Goods and Services
Other Service	Individualized Day Support
Other Service	Interpreter
Other Service	Specialized Medical Equipment and Supplies
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Service Definition (Scope):

Adult day health services are provided through a community-based program designed to meet the needs of cognitively and physically impaired adults through a structure, comprehensive program that provides a variety of health, social and related support services including, but not limited to, socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of a day. There are two different models of adult day health services: the social model and the medical model. Both models shall include the minimum requirements described in Section 17b-342-2(b)(2) of the DSS regulations. In order to qualify as a medical model, adult day health services shall also meet the requirements described in Section 17b-342-2(b)(3) of the DSS regulations. May not be provided at the same time as Community Based Day Support Options, Individualized Day Supports, Supported Employment, or Respite.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency 

Provider Type:

Provider Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider must meet the requirements of Section 17b-342-2(b)(2) of the DSS regulations. Providers of the medical model of Adult Day Health must also meet the requirements of Section 17b-342-2(b)(3) of the DSS regulations

The agency must ensure that all employees meet the following qualifications:

Prior to Employment

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the circle if requested by the individual
- demonstrate understanding of Person Centered Planning
- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DSS Access Agencies

Frequency of Verification:

Every 3 years

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Community Based Day Support Options

Service Definition (Scope):

Services and supports leading to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure and retirement activities. This service is provided by a qualified provider in a facility-based program or appropriate community locations. Transportation to and from home is included as part of this waiver service. The agency rate is adjusted for transportation costs based on mileage and type of vehicle required. This service may not be provided at the same time as Individualized Day Supports, Supported Employment, Adult Day Health or Respite.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 8 hours per day. The Per Diem rate is utilized for participants who regularly receive this service for five and a half hours or more per day.

Service Delivery Method (check each that applies):

☐ Participant-directed as specified in Appendix E

☒ Provider managed

Specify whether the service may be provided by (check each that applies):

☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Community Based Day Support Options

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications:

License (specify):

--

Certificate (specify):

Other Standard (specify):

The agency meets the qualifications described in DDS Procedure PR.015 Qualifying Providers. In addition, the agency ensures that employees meet the following qualifications prior to employment:

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

The agency ensures that employees meet the following qualifications prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the circle if requested by the individual
- demonstrate understanding of Person Centered Planning
- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS Central Office

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Service Definition (Scope):

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care will be provided in the following location(s): Individual's home or place of residence; DDS certified respite care facility; DDS operated respite care facility; DPH certified residential camp program. Respite services may not be provided at the same time as Community Day Support Options, Adult Day Health, Individualized Day, or Supported Employment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The use of this service is limited to a maximum of 14 days per year. The maximum funding allowable for this service is calculated using the rates for the three levels of 24 hour out of home respite. The maximum for Rate 1 is \$1775 annually, Rate 2 is \$2255 annually, and Rate 3 is \$3055 annually. These rates are based on the complexity of the individual's needs as documented by the CT Level of Need Assessment. The Per diem rate is

utilized when the respite is provided for 13 or more hours in a 24 hour period.

Service Delivery Method (*check each that applies*):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
☒ Relative
☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals hired by Participants who Self Direct
Agency	DDS Respite Center or Private Respite Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Individual ▼

Provider Type:

Individuals hired by Participants who Self Direct

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

The FI will verify that the respite provider meets the following qualifications prior to employment:

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*
- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS


Frequency of Verification:

FI Prior to employment

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Respite

Provider Category:Agency **Provider Type:**

DDS Respite Center or Private Respite Facility

Provider QualificationsLicense (*specify*):Certificate (*specify*):Other Standard (*specify*):

Facilities and/or entities and individuals certified in accordance with subsection (d) of Section 17a-218, the regulations promulgated there under, or otherwise certified as a "qualified provider" of respite services by DDS and Reg. Conn. Agencies-DMR Sections 17a-218-8 through 17a-218-17 (The "Respite Regs")

The agency ensures that employees meet the following qualifications:

Prior to Employment

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques

- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan

- demonstrate competence/knowledge in positive behavioral programming, working with individuals who experience moderate to severe psychological and psychiatric behavioral health needs and ability to properly implement behavioral support plans*

- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service	▼
Service:	
Supported Employment	▼
Alternate Service Title (if any):	

Service Definition (Scope):

Supported Employment consists of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of their disabilities, need supports to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a customized job on behalf of the participant. Supported employment is conducted in a variety of community settings where persons without disabilities are employed. Supported Employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for supervisory activities rendered as a normal part of the business setting. Supported employment does not include sheltered work or similar types of vocational services furnished in specialized facilities. Supported employment services may be furnished to participants who are paid at a rate more than minimum wage, provided that the participant requires supported employment services in order to sustain employment. Supported employment services may be furnished by a co-worker or other job-site personnel provided that the services which are furnished are not part of the normal duties of the co-worker or other personnel and those individuals meet the pertinent qualifications for providers of the service. Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
 2. Payments that are passed through to users of supported employment programs;
 3. Payments for vocational training that is not directly related to a participant's supported employment.
- Supported employment services furnished under the waiver are not available under a program funded by either program funded by either the Rehabilitation Act of 1973 or P.L. 94-142.

Transportation to and from the participant's home is included in this service. The agency rate is adjusted for transportation costs based on mileage and type of vehicle required.

May not be provided at the same time as Community Day Supports, Individualized Day Supports, or Respite. Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 8 hours per day or 40 hours per week. Participants in Group Supported Employment must have their supports provided by an agency. The Per Diem rate is utilized for participants who regularly receive this service for five and a half hours or more per day.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:


Provider Category	Provider Type Title
Agency	Provider Agencies
Individual	Individuals Hired by Participants who Self Direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency 

Provider Type:

Provider Agencies

Provider Qualifications

License (*specify*):




Certificate (*specify*):




Other Standard (*specify*):

The agency meets the qualifications described in DDS Procedure PR.015 Qualifying Providers. In addition the agency ensures that employees meet the following qualifications:

Prior to Employment

- 21 years of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the individual

·demonstrate competence in knowledge of DDS policies and procedures; abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse.

·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP

·ability to participate as a member of the circle if requested by the individual

·Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:


Initial and every 2 years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual 

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License (*specify*):




Certificate (*specify*):

Other Standard (specify):

The Fiscal Intermediary ensures that employees meet the following qualifications:

Prior to Employment:

- 21 years of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse.
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP
- ability to participate as a member of the circle if requested by the individual
- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications**Entity Responsible for Verification:**

FI and DDS

Frequency of Verification:

FI Prior to employment

DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Independent Support Broker

Service Definition (Scope):

Support and Consultation provided to individuals and/or their families to assist them in directing their own plan of individual support. This service is limited to those who direct their own supports.

The services included are:

- Assistance with developing a natural community support network
- Assistance with managing the Individual Budget
- Support with and training on how to hire, manage and train staff
- Accessing community activities and services, including helping the individual and family with day to day coordination of needed services.
- Assistance with negotiating rates and reimbursements.
- Developing an emergency back up plan
- Self advocacy training and support

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☐ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies
Individual	Individual Hired by Participants who Self Direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Independent Support Broker

Provider Category:

Agency ☐

Provider Type:

Provider Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The agency meets the qualifications described in DDS Procedure PR.015 Qualifying Providers. In addition, the agency ensures that employees meet the following qualifications prior to employment:

- 21 yrs of age
 - criminal background check
 - registry check
 - demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.
 - Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.
 - One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation.
- Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.
- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual

- abuse, knowledge of approved and prohibited physical management techniques
- demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services
- demonstrate understanding of individual budgets and DDS fiscal management policies

Verification of Provider Qualifications**Entity Responsible for Verification:**

DDS

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Independent Support Broker****Provider Category:**Individual ☒**Provider Type:**

Individual Hired by Participants who Self Direct

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

The FI will ensure that the individual meets the following qualifications prior to employment:

- 21 yrs of age
 - criminal background check
 - registry check
 - demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan.
 - Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and/or implementation of elements in an individual's plan of care.
 - One year of the General Experience must have involved supervision of direct care staff in OR responsibility for developing, implementing and evaluating individualized supports for people with mental retardation in the areas of behavior, education or rehabilitation.
- Substitutions Allowed: College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one-half (1/2) year of experience to a maximum of four (4) years.
- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
 - demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services
 - demonstrate understanding of individual budgets and DDS fiscal management policies

Verification of Provider Qualifications**Entity Responsible for Verification:**

FI and DDS

Frequency of Verification:

FI Prior to Employment

DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

☐ Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Support Services

Service Definition (Scope):

Clinical and therapeutic services which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. This service is available to individuals who have intellectual disabilities and demonstrate an emotional, behavioral or mental health issue that results in the functional impairment of the individual and substantially interferes with or limits functioning at home or in the community. Professional clinical service to include: 1) Assess and evaluate the behavioral and clinical need (s); 2) Develop a behavioral support plan that includes intervention techniques as well as teaching strategies for increasing new adaptive positive behaviors, and decreasing challenging behaviors addressing these needs in the individual's natural environments; 3) Provide training to the individual's family and the support providers in appropriate implementation of the behavioral support plan and associated documentation; and, 4) Evaluate the effectiveness of the behavioral support plan by monitoring the plan on a monthly basis, and by meeting with the team one month after the implementation of the behavior plan, and in future three month intervals. The service will include any changes to the plan when necessary and the professional(s) shall be available to the team for questions and consultation. The professional(s) shall make recommendations to the Individual Support Team and Case Manager for referrals to community physicians and other clinical professionals that support the recommendations of the assessment findings as appropriate. Use of this service requires the preparation of a formal comprehensive assessment and submission of any restrictive behavioral support program to the DDS Program Review Committee for approval prior to implementation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:




Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Board Certified Behavior Analyst
Individual	Master's Level Behavioral Support Provider
Individual	LCSW
Individual	Psychologist

Appendix C: Participant Services

C-1/C-3: PROVIDER SPECIFICATIONS FOR SERVICE

Service Type: Other Service
Service Name: Behavioral Support Services
Provider Category: <input type="text" value="Individual"/>
Provider Type: Board Certified Behavior Analyst
Provider Qualifications License (specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Certificate (specify): Current certification as a Board Certified Behavioral Analyst (BCBA)
Other Standard (specify): <ul style="list-style-type: none"> Two years of experience providing behavioral supports to people with developmental disabilities. Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2's) Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the person's Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.
Verification of Provider Qualifications Entity Responsible for Verification: FI and DDS
Frequency of Verification: FI Prior to Employment for consumer directed services DDS Annual verification of ongoing licensure.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Support Services
Provider Category: <input type="text" value="Individual"/>
Provider Type: Master's Level Behavioral Support Provider
Provider Qualifications License (specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Certificate (specify): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Standard (specify): <ul style="list-style-type: none"> Master's degree in psychology, special education, social work or a related field. Two years of experience providing behavioral supports to people with developmental disabilities. Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2's) Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the person's Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.
Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to Employment for consumer directed services

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Behavioral Support Services**Provider Category:**

Individual ▼

Provider Type:

LCSW

Provider Qualifications**License (specify):**

Licensure per CGS Chapter 383b (Licensed Clinical Social Worker)

Certificate (specify):**Other Standard (specify):**

- Two years of experience providing behavioral supports to people with developmental disabilities.
- Review of all application materials and approval by the Operations Center and its designee (DDS Supervising Psychologist 2's)
- Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the person's Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.

Verification of Provider Qualifications**Entity Responsible for Verification:**

FI and DDS

Frequency of Verification:

FI Prior to Employment for consumer directed services

DDS Annual verification of ongoing licensure.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type:** Other Service**Service Name:** Behavioral Support Services**Provider Category:**

Individual ▼

Provider Type:

Psychologist

Provider Qualifications**License (specify):**

Licensed by the American Psychological Association and meets requirements of Connecticut General Statutes Chapter 383

Certificate (specify):**Other Standard (specify):**

- Two years of experience providing behavioral supports to people with developmental disabilities.
- Review of all application materials and approval by the Operations Center and its designee (DDS

Supervising Psychologist 2's)

· Criminal background check, DDS Abuse/Neglect Registry check and Sex Offender Registry check required. When an individual self directs, these checks are done by the person's Fiscal Intermediary; if the service is purchased through an agency, the provider is responsible for conducting these checks for their employees.

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to Employment for consumer directed services

DDS Annual verification of ongoing licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ☒

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Goods and Services

Service Definition (Scope):

Services, equipment or supplies that will provide direct benefit to the individual and support specific outcomes identified in the Individual Plan. The service, equipment or supply must either reduce the reliance of the individual on other paid supports, be directly related to the health and/or safety of the individual in his/her home or in the community, be habilitative in nature and contribute to a therapeutic goal, enhance the individual's ability to be integrated into the community, or provide resources to expand self-advocacy skills and knowledge, and, the individual has no other funds to purchase the described goods or services. DDS Cost Standards are a set of guidelines which are used to ensure applies consistent criteria with respect to the appropriateness of the services or items to be approved in this service definition and their cost. Experimental and prohibited treatments are excluded. This service is only available for individuals who self-direct their own supports, and must be pre-approved by DDS and follow DDS Cost Standards. DDS applies consistent guidelines in respect to the appropriateness of the services or items to be approved in this service definition. This service may not duplicate any Medicaid State Plan service. Direct supports under this service may not be provided at the same time as Individualized Day Supports, Group Day, Supported Employment, Respite, Individualized Home Supports, Adult Companion, or Personal Support.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

	<input type="button" value="Up"/> <input type="button" value="Down"/>
--	--------------------------------------------------------------------------

Service Delivery Method (check each that applies):

☒ Participant-directed as specified in Appendix E

☐ Provider managed

Specify whether the service may be provided by (check each that applies):

☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian

Provider Specifications:

--	--

Provider Category	Provider Type Title
Agency	Provider agency or Private Vendor
Individual	Participant directed Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Goods and Services

Provider Category:

Agency ☒

Provider Type:

Provider agency or Private Vendor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Meets any applicable state regulations for the type of supply or service as described in the Individual Plan approved by DDS.

If the participant is purchasing direct supports the agency will ensure that employees meet the following qualifications prior to employment:

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the circle if requested by the individual
- demonstrate understanding of Person Centered Planning
- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Goods and Services

Provider Category:

Individual ▾

Provider Type:

Participant directed Individual

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Meets any applicable state regulations for the type of supply or service as described in the Individual Plan approved by DDS.

If the participant is purchasing direct support the FI will ensure that the person hired meets the following qualifications prior to employment:

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the circle if requested by the individual
- demonstrate understanding of Person Centered Planning
- Medication Administration*

* if required by the individual supported

Verification of Provider Qualifications**Entity Responsible for Verification:**

FI and DDS

Frequency of Verification:

FI Prior to employment

DDS Annual sample of consumer directed persons

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▾

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individualized Day Support

Service Definition (Scope):

Services and supports provided to individuals tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, or for an individual who has their own business, and could not do so without this direct support. This service emanates from the participant's home and

is not delivered in or from a facility-based program. All transportation costs are included in the rate. May not be provided at the same time as Community Day Support Options, Supported Employment, Adult Day Health or Respite.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to no more than 8 hours per day.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☒ Relative
☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Individuals Hired by Participants who Self Direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individualized Day Support

Provider Category:

Agency ☐

Provider Type:

Provider Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The agency meets the qualifications described in DDS Procedure DDS PR.015. In addition, the agency ensures that employees meet the following qualifications:

Prior to Employment:

- 21 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the circle if requested by the individual


- demonstrate understanding of Person Centered Planning
 - Medication Administration*
 - * if required by the individual supported
- Verification of Provider Qualifications**
Entity Responsible for Verification:
 DDS
Frequency of Verification:
 Initial and every 2 years thereafter.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Day Support

Provider Category:

Individual 

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The FI ensures that employee meet the following qualifications:

Prior to Employment:

- 21 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

- demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques
- demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
- demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
- ability to participate as a member of the team if requested by the individual
- demonstrate understanding of Person Centered Planning
- Medication Administration*
- * if required by the individual supported

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment

DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Interpreter

Service Definition (Scope):

Service of an interpreter to provide accurate, effective, and impartial communication where the waiver recipient or representative is deaf or hard of hearing or where the individual does not understand spoken English.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
- ☐ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals Hired by Participants who Self Direct
Agency	Private or public translation service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Interpreter

Provider Category:

Individual

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License (specify):

Certificate (specify):

Sign language interpreter: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired.

Other Standard (specify):

Any other language interpreter:

Prior to Employment

·18 yrs of age

·criminal background check

·registry check

- have ability to communicate effectively with the individual/family
- be proficient in both languages
- be committed to confidentiality
- understand cultural nuances and emblems
- understands the interpreter's role to provide accurate interpretation

Verification of Provider Qualifications**Entity Responsible for Verification:**

FI and DDS

Frequency of Verification:


FI Prior to employment

DDS Quality Management staff conduct an annual Quality Service Review on a sample of consumer directed persons. Review includes verification of training qualifications.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Interpreter

Provider Category:Agency **Provider Type:**

Private or public translation service

Provider Qualifications**License (specify):**




Certificate (specify):

Sign language interpreter: Certified by National Assn. Of the Deaf or National registry of Interpreters for the Deaf. Sign language interpreters must be registered with the Commission on the Deaf and Hearing Impaired.

Other Standard (specify):

For any other language interpreter the agency ensures that employees meet the following qualifications:

Prior to Employment:

- 18 yrs of age
- criminal background check
- registry check
- have ability to communicate effectively with the individual/family
- be proficient in both languages
- be committed to confidentiality
- understand cultural nuances and emblems
- understands the interpreter's role to provide accurate interpretation

Verification of Provider Qualifications**Entity Responsible for Verification:**

DDS

Frequency of Verification:

Initial and every 2 years thereafter.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

Service Definition (Scope):

Devices, controls, or appliances specified in the Individual Plan, which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Prior approval will be required with documentation by a licensed medical or therapy professional for single items costing more than \$250. The benefit package is limited to \$500 per year.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vendors of Specialized Medical Equipment and Supplies

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Vendors of Specialized Medical Equipment and Supplies

Provider Qualifications**License (specify):**

Pharmacies: CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7.

Certificate (specify):

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Other Standard (specify):

Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8)
 Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91
 Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52).

Verification of Provider Qualifications**Entity Responsible for Verification:**

DDS


Frequency of Verification:

Initial and as needed thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

Service Definition (Scope):

Service offered in order to enable individuals to get to their place of employment or their community based day supports. Payment per mile is made for a maximum of one round trip daily. Prior Approval must be obtained in order to utilize the per trip rate for a participant. Wheelchair accessible transportation is paid at a higher rate only if the individual requires the use of a wheelchair accessible vehicle.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is only available to individuals in Community Based Day Support Options, and Supported Employment.

Service Delivery Method (check each that applies):

- ☒ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
☒ Relative
☒ Legal Guardian

Provider Specifications:


Provider Category	Provider Type Title
Agency	Private agency qualified to provide transportation.
Individual	Individuals Hired by Participants who Self Direct

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Transportation

Provider Category:

Agency 

Provider Type:

Private agency qualified to provide transportation.

Provider Qualifications

License (specify):

Valid CT driver's license

Certificate (specify):




Other Standard (specify):

Certificate of insurance.
Verification of Provider Qualifications
Entity Responsible for Verification:
 DDS
Frequency of Verification:
 Initial and every 2 years certification thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual ☐

Provider Type:

Individuals Hired by Participants who Self Direct

Provider Qualifications

License (specify):

Valid CT Driver's License

Certificate (specify):

Other Standard (specify):

The FI will ensure that employees meet the following qualifications:

Prior to Employment:

Proof of insurance

· 18 yrs of age

· criminal background check

· registry check

· have ability to communicate effectively with the individual/family

· have ability to complete record keeping as required by the employer

Prior to being alone with the Individual:

· demonstrate competence in knowledge of DDS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques

Verification of Provider Qualifications

Entity Responsible for Verification:

FI and DDS

Frequency of Verification:

FI Prior to employment

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

☐ Not applicable - Case management is not furnished as a distinct activity to waiver participants.

☒ Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

☐ As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete

item C-1-c.

☒ As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete*

item C-1-c.

☐ As an administrative activity. *Complete item C-1-c.*

- c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State of CT Department of Developmental Services

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

☐ No. Criminal history and/or background investigations are not required.

☒ Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Direct Support and professional support services under the following service definitions are required to submit to state (CT) only criminal checks. This includes all staff employed under behavioral supports, community day support options, supported employment, respite, adult day health, individual goods and services, interpreters, and transportation providers. Criminal background checks for providers of the following services may be required if requested by the individual receiving the supports or their representative: clinical behavioral support. Vendors enrolled as specialized medical and adaptive equipment are not required to submit to criminal background checks.

The process for ensuring that mandatory investigations have been completed depends upon the service and the hiring entity. The V/FEA is required to obtain a criminal background check for any service vendor hired through the consumer-directed process prior to processing any employment paperwork or permitting the employee to begin work. DDS conducts annual FI audits for consumer-directed services to ensure that the required criminal background checks are conducted. For individually enrolled vendors, criminal background checks are required to enroll in the DDS HCBS waiver program and receive a provider agreement. For services operated by larger vendor agencies, the vendor agency agrees to obtain a criminal background check for any individual who provides the specified services as part of the Medicaid Provider Agreement. When an incident involving abuse/neglect or other misconduct by an employee reveals that the employee has a criminal history DDS Policy requires that DDS conducts an inquiry into the vendor agency's compliance with conducting criminal background checks.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

☐ No. The State does not conduct abuse registry screening.

☒ Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DDS maintains an abuse/neglect registry pursuant to CT General Statutes 17a-247a-17a-247e. All employees of

DDS or agencies funded or licensed by DDS who are found guilty of abuse and terminated or separated from employment are subject to inclusion on the registry. The fiscal intermediary is required to ensure the abuse/neglect registry has been checked for all individual employees sought to be hired through consumer-direction. The DDS and private vendor is required to check the registry prior to hiring any employee who will deliver services. The DDS monitors this expectation during annual FI audits and at the vendor level through bi-annual Quality Service Reviews conducted by DDS.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ☒ No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.
- ☐ Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
- ☐ Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☒ The State does not make payment to relatives/legal guardians for furnishing waiver services.
- ☐ The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Requests to permit payment to relatives/legal guardians for furnishing the following waiver services: Individualized Day Supports, Supported Employment, Respite, and Transportation are only permitted under consumer directed services, and must be approved by the DDS prior approval committee. This committee ensures that the provision of service is in the best interest of the participant. Additional controls include the required use of a support broker to ensure that the individual has engaged in recruitment activities; and the requirement that there is a responsible person other than the paid family member, who, in addition to the participant, assumes employer responsibilities including verification that payments are made only for services rendered. Circumstances where this may be permitted are limited to relatives/legal guardians who possess the medical skills necessary to safely support the individual, or, when the Prior Approval Committee determines that qualified staff are otherwise not available. Payment to family members is only made when the service provided is not a function that a family member would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family; and, the service would otherwise need to be provided by a qualified provider.

- ☐ Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ Other policy.

Specify:

- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All information regarding requirements for and instructions to enroll as a qualified provider for the DDS HCBS waivers is posted to the DDS web site. DDS completes the evaluation of qualified providers and notifies DSS for final provider enrollment. Any provider of services may submit an application for enrollment to the DDS Operations Center for any service at any time.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new provider applicants qualified per DDS Procedure.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Application packet

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: <div></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

Performance Measure:

DDS reviews and verifies continued professional licensure and certification of qualified providers annually. Number and percent of professionals who submit licensure or certification documentation annually.

Data Source (Select one):

Other

If 'Other' is selected, specify:
professional credentials

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each)	Frequency of data aggregation and analysis (check each that applies):

<i>that applies):</i>	
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; position: relative;"> <div style="position: absolute; right: 0; top: 0; bottom: 0; width: 10px; text-align: center;"> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▲</div> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▼</div> </div> </div>	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; position: relative;"> <div style="position: absolute; right: 0; top: 0; bottom: 0; width: 10px; text-align: center;"> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▲</div> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▼</div> </div> </div>	

Performance Measure:
 Number and percent of providers certified.

Data Source (Select one):
 Provider performance monitoring
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; position: relative;"> <div style="position: absolute; right: 0; top: 0; bottom: 0; width: 10px; text-align: center;"> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▲</div> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▼</div> </div> </div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; position: relative;"> <div style="position: absolute; right: 0; top: 0; bottom: 0; width: 10px; text-align: center;"> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▲</div> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▼</div> </div> </div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; position: relative;"> <div style="position: absolute; right: 0; top: 0; bottom: 0; width: 10px; text-align: center;"> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▲</div> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▼</div> </div> </div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; position: relative;"> <div style="position: absolute; right: 0; top: 0; bottom: 0; width: 10px; text-align: center;"> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▲</div> <div style="border-top: 1px solid black; border-bottom: 1px solid black; height: 10px; margin: 0 2px;">▼</div> </div> </div>
	<input type="checkbox"/> Other Specify:	

--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. *Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of non-certified/non-licensed providers who meet waiver requirements.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100 % Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div><div></div><div></div></div>
<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div><div></div><div></div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>
	<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div><div></div><div></div></div>

Performance Measure:

Number and percent of staff newly hired by participants who are qualified to provide service.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Employment applications, Criminal History Background Checks and training records.

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediaries	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediaries	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of "Met" QSR indicators that relate to support person training.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100 % Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100 % Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: random sample of staff training records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 150px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 150px; margin-top: 5px;"></div>

Performance Measure:

Number and percent of direct hire staff who have received required training.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100 % Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediaries	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Fiscal Intermediaries	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When issues are identified qualified providers are required to submit a plan of correction with timeframes for completion. If a provider continues to have less than acceptable performance they can be put on enhanced monitoring, can be prohibited from serving any new participants until their performance has reached an acceptable level of quality, can lose their status as a qualified provider for the service(s) with less than acceptable quality, and/or can be removed as a qualified provider altogether.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☐ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☒ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

	<input type="button" value="Up"/> <input type="button" value="Down"/>
--	--------------------------------------------------------------------------

- ☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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- ☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Each individual receives a budget allocation based on the results of the participant's assessed Level of Need. The Level of Need is determined as a result of the completed CT Level of Need Assessment and Risk Screening Tool (LON). The resulting score of 0-8 is associated with a prospective individual funding amount for vocational related services and respite services. The LON Assessment and preliminary associated funding levels were developed under the CMS Independence Plus Grant using qualitative and quantitative methodologies. The bulk of the historical financial data used to calculate these rates includes information on individuals who were served on Master Contracts prior to the conversion to the present Fee for Service model. The state applies legislatively approved adjustments to these dollar amounts each year the waiver is in effect. Individuals with scores of 8 have exceptional support needs and will receive and allocation based on their individual support needs. Applicants with a LON score of 0 will not be eligible to receive waiver services since they will not meet the Level of Care criteria. People with approved support packages that exceed \$25,000 are enrolled in either the IFS or the Comprehensive Waiver. During the period covered by this waiver the analysis of the data will continue and allocations will be modified according to the results of the analyses.

The DDS Regional Planning and Resource Allocation Team notifies the applicant of the funding limit via letter as described in Appendix D. The budget allocation limits apply to all services with the exception of Specialized Adaptive Equipment, which is not an annualized services. Adjustments to the budget allocation limit can be made either as a result of an assessed Level of Need which results in an increased or decreased LON score, or due to short-term circumstances necessitating an increased amount of services to address short term health and safety needs.

- ☐ Other Type of Limit. The State employs another type of limit.

Describe the limit and furnish the information specified above.

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Plan

- a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ Registered nurse, licensed to practice in the State
- ☐ Licensed practical or vocational nurse, acting within the scope of practice under State law
- ☐ Licensed physician (M.D. or D.O.)
- ☐ Case Manager (qualifications specified in Appendix C-1/C-3)
- ☒ Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

DDS Case Managers (TCM) are state employees who meet the following qualifications: considerable understanding of nature of clinical assessments; considerable knowledge of services available to persons with mental retardation; knowledge of residential programs for persons with mental retardation; knowledge of interdisciplinary approach to program planning; knowledge of mental retardation, causes and treatment; considerable skill in facilitating positive group process; oral and written communication skills; considerable ability to translate clinical findings and recommendations into program activities and develop realistic program objectives; ability to collect and analyze large amounts of information; familiar with automated data systems.

- ☐ Social Worker.

Specify qualifications:

	<input type="button" value="Up"/> <input type="button" value="Down"/>
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- ☐ Other

Specify the individuals and their qualifications:

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of the charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting of the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1 Year	Col. 2 Factor D	Col. 3 Factor D'	Col. 4 Total: D+D'	Col. 5 Factor G	Col. 6 Factor G'	Col. 7 Total: G+G'	Col. 8 Difference (Col 7 less Column4)
1	20245.49	9181.00	29426.49	229432.00	3933.00	233365.00	203938.51
2	20834.25	9502.00	30336.25	233103.00	4051.00	237154.00	206817.75
3	21468.89	9835.00	31303.89	236833.00	4172.00	241005.00	209701.11

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/MR	
Year 1	200		200
Year 2	300		300
Year 3	400		400

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Based on the 2008 CMS Form 372 for 0426-IP which serves a similar target population.

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (3 of 7)**

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates of Factor D are based on past utilization of services in the other DDS waivers prorated for estimates of increased enrollment.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was based on the 372 report for the DDS IFS waiver 0426-IP which was filed in 2008

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was based on the 372 report for the DDS IFS waiver 0426-IP which was filed in 2008

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was based on the 372 report for the DDS IFS waiver 0426-IP which was filed in 2008

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (4 of 7)**

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Health
Community Based Day Support Options
Respite
Supported Employment
Independent Support Broker
Behavioral Support Services
Individual Goods and Services
Individualized Day Support
Interpreter
Specialized Medical Equipment and Supplies
Transportation

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (5 of 7)**

- d. **Estimate of Factor D.**

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						12436.00
Adult Day Health	Per diem	1	200.00	62.18	12436.00	
Adult Day Health--Medical	Per diem	0	0.00	66.22	0.00	
Adult Day Health--Half Day	Per diem	0	0.00	40.54	0.00	
Community Based Day Support Options Total:						1345949.56
LON Level 1	Per 15 minutes	1	4860.00	2.09	10157.40	
LON Level 2	Per 15 minutes	4	4860.00	2.79	54237.60	
LON Level 3	Per 15 minutes	4	4860.00	3.48	67651.20	
LON Level 4	Per 15 minutes	3	4860.00	3.83	55841.40	
LON Level 5	Per 15 minutes	12	4860.00	4.18	243777.60	
LON Level 6	Per 15 minutes	11	4860.00	4.53	242173.80	
LON Level 1	Per diem	1	202.00	50.16	10132.32	
LON Level 2	Per diem	4	202.00	66.88	54039.04	
LON Level 3	Per diem	4	202.00	83.60	67548.80	
LON Level 4	Per diem	3	202.00	91.96	55727.76	
LON Level 5	Per diem	12	202.00	100.32	243175.68	
LON Level 6	Per diem	11	202.00	108.68	241486.96	
Respite Total:						280270.23
Group Respite Per Diem -- Rate 1--Agency	Per Diem	40	9.00	126.80	45648.00	
Group Respite Per Diem--Rate 2--Agency	Per Diem	45	9.00	161.07	65233.35	
Group Respite Per Diem--Rate 3--Agency	Per Diem	60	9.00	218.09	117768.60	
Individual In Home Respite Per Diem--Direct Hire	Per Diem	2	9.00	208.54	3753.72	
Individual In Home Respite Per Diem--Agency	Per Diem	2	9.00	299.07	5383.26	
Individual In Home Respite Per 15 minutes--Direct Hire	Per 15 minutes	2	400.00	4.25	3400.00	
Individual In Home Respite Per 15 minutes--Agency	Per 15 minutes	2	400.00	6.23	4984.00	
Individual Out of Home Respite Per 15 minutes--Direct Hire	Per 15 minutes	2	400.00	4.75	3800.00	
Individual Out of Home Respite Per 15 minutes--Agency	Per 15 minutes	2	400.00	6.51	5208.00	

Individual Out of Home Respite Per Diem--Direct Hire	Per Diem	2	5.00	244.95	2449.50
Individual Out of Home Respite Per Diem--Agency	Per Diem	2	5.00	326.18	3261.80
Two Person In Home Respite Per Diem--Direct Hire	Per Diem	0	5.00	156.41	0.00
Two Person In Home Respite Per Diem--Agency	Per Diem	0	5.00	186.92	0.00
Two Person Out of Home Respite Per Diem--Direct Hire	Per Diem	0	5.00	183.41	0.00
Two Person Out of Home Respite Per Diem--Agency	Per Diem	0	5.00	214.03	0.00
Two Person In Home Respite Per 15 Minutes--Agency	Per 15 minutes	0	400.00	3.90	0.00
Two Person Out of Home Respite Per 15 Minutes--Agency	Per 15 minutes	0	400.00	4.18	0.00
Two Person In Home Respite Per 15 Minutes--Direct Hire	Per 15 minutes	0	400.00	3.26	0.00
Two Person Out of Home Respite Per 15 Minutes--Direct Hire	Per 15 minutes	0	400.00	4.08	0.00
Group Respite In Home Per Diem--Direct Hire	Per Diem	0	400.00	139.03	0.00
Group Respite Out of Home Per Diem--Direct Hire	Per Diem	0	400.00	163.30	0.00
Group Respite Per 15 Minutes--Rate 1--Agency	Per 15 minutes	5	400.00	2.36	4720.00
Group Respite Per 15 Minutes--Rate 2--Agency	Per 15 minutes	5	400.00	3.07	6140.00
Group Respite Per 15 Minutes--Rate 3--Agency	Per 15 minutes	5	400.00	4.26	8520.00
Supported Employment Total:					2037169.62
Individual Supported Employment	Per 15 minutes	26	1409.00	14.53	532292.02
Group Supported Employment LON Level 1	Per 15 minutes	11	4860.00	2.09	111731.40
Group Supported Employment LON Level 2	Per 15 minutes	14	4860.00	2.79	189831.60
Group Supported Employment LON Level 3	Per 15 minutes	9	4860.00	3.48	152215.20
Group Supported Employment LON Level 4	Per 15 minutes	5	4860.00	3.83	93069.00
Group Supported Employment LON Level 5	Per 15 minutes	8	4860.00	4.18	162518.40
Group Supported Employment LON Level 6	Per 15 minutes	2	4860.00	4.53	44031.60
Group Supported Employment LON Level 1	Per Diem	11	202.00	50.16	111455.52
Group Supported Employment LON Level 2	Per Diem	14	202.00	66.88	189136.64
Group Supported Employment LON Level 3	Per Diem	9	202.00	83.60	151984.80
Group Supported Employment LON Level 4	Per Diem	5	202.00	91.96	92879.60
Group Supported Employment LON Level 5	Per Diem	8	202.00	100.32	162117.12
Group Supported Employment LON Level 6	Per Diem	2	202.00	108.68	43906.72
Independent Support Broker Total:					19337.50

Independent Support Broker	Per 15 Minutes	7	221.00	12.50	19337.50	
Behavioral Support Services Total:						108000.00
Behavioral Support Services	Per 15 minutes	30	120.00	30.00	108000.00	
Individual Goods and Services Total:						6000.00
Individual Goods and Services	Per Service	10	6.00	100.00	6000.00	
Individualized Day Support Total:						200507.66
Agency Rate	Per 15 minutes	4	4860.00	8.05	156492.00	
Individual Rate	Per 15 minutes	2	3937.00	5.59	44015.66	
Interpreter Total:						8304.00
Interpreter--Language	Per 15 minutes	4	96.00	18.75	7200.00	
Interpreter--American Sign Language	Per 15 minutes	1	96.00	11.50	1104.00	
Specialized Medical Equipment and Supplies Total:						2500.00
Specialized Medical Equipment and Supplies	Per Service	5	1.00	500.00	2500.00	
Transportation Total:						28623.40
Per mile--Agency	Per mile	12	2020.00	0.86	20846.40	
Per trip	Per Trip	0	202.00	29.71	0.00	
Wheelchair per mile	Per mile	1	2020.00	1.70	3434.00	
Per mile--Individual	Per mile	5	2020.00	0.43	4343.00	
GRAND TOTAL:					4049097.97	
Total Estimated Unduplicated Participants:					200	
Factor D (Divide total by number of participants):					20245.49	
Average Length of Stay on the Waiver:					356	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						12746.00

Adult Day Health	Per Diem	1	200.00	63.73	12746.00	
Adult Day Health--Medical	Per diem	0	0.00	67.88	0.00	
Adult Day Health--Half Day	Per diem	0	0.00	41.55	0.00	
Community Based Day Support Options Total:						2027629.64
LON Level 1	Per 15 minutes	1	4860.00	2.15	10449.00	
LON Level 2	Per 15 minutes	6	4860.00	2.87	83689.20	
LON Level 3	Per 15 minutes	6	4860.00	3.58	104392.80	
LON Level 4	Per 15 minutes	4	4860.00	3.94	76593.60	
LON Level 5	Per 15 minutes	18	4860.00	4.31	377038.80	
LON Level 6	Per 15 minutes	16	4860.00	4.67	363139.20	
LON Level 1	Per diem	1	202.00	51.66	10435.32	
LON Level 2	Per diem	6	202.00	68.89	83494.68	
LON Level 3	Per diem	6	202.00	86.11	104365.32	
LON Level 4	Per diem	4	202.00	94.72	76533.76	
LON Level 5	Per diem	18	202.00	103.33	375707.88	
LON Level 6	Per diem	16	202.00	111.94	361790.08	
Respite Total:						445650.82
Group Respite Per Diem -- Rate 1--Agency	Per Diem	60	9.00	130.60	70524.00	
Group Respite Per Diem--Rate 2--Agency	Per Diem	60	9.00	165.90	89586.00	
Group Respite Per Diem--Rate 3--Agency	Per Diem	100	9.00	224.63	202167.00	
Individual In Home Respite Per Diem--Direct Hire	Per Diem	2	9.00	214.80	3866.40	
Individual In Home Respite Per Diem--Agency	Per Diem	2	9.00	308.04	5544.72	
Individual In Home Respite Per 15 minutes--Direct Hire	Per 15 minutes	2	400.00	4.38	3504.00	
Individual In Home Respite Per 15 minutes--Agency	Per 15 minutes	2	400.00	6.42	5136.00	
Individual Out of Home Respite Per 15 minutes--Direct Hire	Per 15 minutes	2	400.00	4.89	3912.00	
Individual Out of Home Respite Per 15 minutes--Agency	Per 15 minutes	2	400.00	6.71	5368.00	
Individual Out of Home Respite Per Diem--Direct Hire	Per Diem	2	5.00	252.30	2523.00	
Individual Out of Home Respite Per Diem--Agency	Per Diem	2	5.00	335.97	3359.70	
Two Person In Home Respite Per Diem--Direct Hire	Per Diem	0	5.00	161.10	0.00	
Two Person In Home Respite Per Diem--Agency	Per Diem	0	5.00	192.53	0.00	
Two Person Out of Home Respite Per Diem--Direct Hire	Per Diem	0	5.00	188.91	0.00	

Two Person Out of Home Respite Per Diem--Agency	Per Diem	0	5.00	220.45	0.00	
Two Person In Home Respite Per 15 Minutes--Agency	Per 15 minutes	0	400.00	4.02	0.00	
Two Person Out of Home Respite Per 15 Minutes--Agency	Per 15 minutes	0	400.00	4.31	0.00	
Two Person In Home Respite Per 15 Minutes--Direct Hire	Per 15 minutes	0	400.00	3.36	0.00	
Two Person Out of Home Respite Per 15 Minutes--Direct Hire	Per 15 minutes	0	400.00	4.20	0.00	
Group Respite In Home Per Diem--Direct Hire	Per Diem	0	5.00	143.20	0.00	
Group Respite Out of Home Per Diem--Direct Hire	Per Diem	0	5.00	168.20	0.00	
Group Respite Per 15 Minutes--Rate 1--Agency	Per 15 minutes	5	400.00	2.43	4860.00	
Group Respite Per 15 Minutes--Rate 2--Agency	Per 15 minutes	15	400.00	3.16	18960.00	
Group Respite Per 15 Minutes--Rate 3--Agency	Per 15 minutes	15	400.00	4.39	26340.00	
Supported Employment Total:						3194114.26
Individual Supported Employment	Per 15 minutes	40	1409.00	14.97	843709.20	
Group Supported Employment LON Level 1	Per 15 minutes	16	4860.00	2.15	167184.00	
Group Supported Employment LON Level 2	Per 15 minutes	21	4860.00	2.87	292912.20	
Group Supported Employment LON Level 3	Per 15 minutes	14	4860.00	3.58	243583.20	
Group Supported Employment LON Level 4	Per 15 minutes	8	4860.00	3.94	153187.20	
Group Supported Employment LON Level 5	Per 15 minutes	12	4860.00	4.31	251359.20	
Group Supported Employment LON Level 6	Per 15 minutes	3	4860.00	4.67	68088.60	
Group Supported Employment LON Level 1	Per Diem	16	202.00	51.66	166965.12	
Group Supported Employment LON Level 2	Per Diem	21	202.00	68.89	292231.38	
Group Supported Employment LON Level 3	Per Diem	14	202.00	86.11	243519.08	
Group Supported Employment LON Level 4	Per Diem	8	202.00	94.72	153067.52	
Group Supported Employment LON Level 5	Per Diem	12	202.00	103.33	250471.92	
Group Supported Employment LON Level 6	Per Diem	3	202.00	111.94	67835.64	
Independent Support Broker Total:						14232.40
Independent Support Broker	Per 15 Minutes	5	221.00	12.88	14232.40	
Behavioral Support Services Total:						185400.00
Behavioral Support Services	Per 15 minutes	50	120.00	30.90	185400.00	
Individual Goods and Services Total:						9270.00
Individual Goods and Services	Per Service	15	6.00	103.00	9270.00	

Individualized Day Support Total:						294566.04
Agency Rate	Per 15 minutes	9	2732.00	8.29	203834.52	
Individual Rate	Per 15 minutes	4	3938.00	5.76	90731.52	
Interpreter Total:						13397.76
Interpreter--Language	Per 15 minutes	6	96.00	19.31	11122.56	
Interpreter--American Sign Language	Per 15 minutes	2	96.00	11.85	2275.20	
Specialized Medical Equipment and Supplies Total:						4120.00
Specialized Medical Equipment and Supplies	Per Service	8	1.00	515.00	4120.00	
Transportation Total:						49146.60
Per mile--Agency	Per mile	17	2020.00	0.89	30562.60	
Per trip	Per Trip	1	202.00	30.60	6181.20	
Wheelchair per mile	Per mile	2	2020.00	1.75	7070.00	
Per mile--Individual	Per mile	6	2020.00	0.44	5332.80	
GRAND TOTAL:						6250273.52
Total Estimated Unduplicated Participants:						300
Factor D (Divide total by number of participants):						20834.25
Average Length of Stay on the Waiver:						356

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						26128.00
Adult Day Health	Per Diem	2	200.00	65.32	26128.00	
Adult Day Health--Medical	Per diem	0	0.00	69.58	0.00	
Adult Day Health--Half Day	Per diem	0	0.00	42.59	0.00	
Community Based Day Support Options Total:						2756197.88
LON Level 1	Per 15 minutes	2	4860.00	2.21	21481.20	

LON Level 2	Per 15 minutes	7	4860.00	2.96	100699.20	
LON Level 3	Per 15 minutes	8	4860.00	3.69	143467.20	
LON Level 4	Per 15 minutes	5	4860.00	4.06	98658.00	
LON Level 5	Per 15 minutes	24	4860.00	4.44	517881.60	
LON Level 6	Per 15 minutes	21	4860.00	4.81	490908.60	
LON Level 1	Per diem	2	202.00	53.21	21496.84	
LON Level 2	Per diem	8	202.00	70.96	114671.36	
LON Level 3	Per diem	8	202.00	88.69	143323.04	
LON Level 4	Per diem	5	202.00	97.56	98535.60	
LON Level 5	Per diem	24	202.00	106.43	515972.64	
LON Level 6	Per diem	21	202.00	115.30	489102.60	
Respite Total:						509961.14
Group Respite Per Diem -- Rate 1--Agency	Per Diem	40	9.00	134.52	48427.20	
Group Respite Per Diem-- Rate 2--Agency	Per Diem	65	9.00	170.88	99964.80	
Group Respite Per Diem-- Rate 3--Agency	Per Diem	110	9.00	231.37	229056.30	
Individual In Home Respite Per Diem--Direct Hire	Per Diem	3	9.00	221.24	5973.48	
Individual In Home Respite Per Diem--Agency	Per Diem	3	9.00	317.28	8566.56	
Individual In Home Respite Per 15 minutes--Direct Hire	Per 15 minutes	3	400.00	4.51	5412.00	
Individual In Home Respite Per 15 minutes--Agency	Per 15 minutes	3	400.00	6.61	7932.00	
Individual Out of Home Respite Per 15 minutes--Direct Hire	Per 15 minutes	3	400.00	5.04	6048.00	
Individual Out of Home Respite Per 15 minutes--Agency	Per 15 minutes	3	400.00	6.91	8292.00	
Individual Out of Home Respite Per Diem--Direct Hire	Per Diem	3	5.00	259.87	3898.05	
Individual Out of Home Respite Per Diem--Agency	Per Diem	3	5.00	346.05	5190.75	
Two Person In Home Respite Per Diem--Direct Hire	Per Diem	0	5.00	165.93	0.00	
Two Person In Home Respite Per Diem--Agency	Per Diem	0	5.00	198.31	0.00	
Two Person Out of Home Respite Per Diem--Direct Hire	Per Diem	0	5.00	194.58	0.00	
Two Person Out of Home Respite Per Diem--Agency	Per Diem	0	5.00	227.06	0.00	
Two Person In Home Respite Per 15 Minutes--Agency	Per 15 minutes	0	5.00	4.14	0.00	
Two Person Out of Home Respite Per 15 Minutes--Agency	Per 15 minutes	0	5.00	4.44	0.00	
Two Person In Home Respite Per 15 Minutes--Direct Hire	Per 15 minutes	0	400.00	3.46	0.00	

Two Person Out of Home Respite Per 15 Minutes--Direct Hire	Per 15 minutes	0	400.00	4.33	0.00	
Group Respite In Home Per Diem--Direct Hire	Per Diem	0	5.00	147.50	0.00	
Group Respite Out of Home Per Diem--Direct Hire	Per Diem	0	5.00	173.25	0.00	
Group Respite Per 15 Minutes--Rate 1--Agency	Per 15 minutes	10	400.00	2.50	10000.00	
Group Respite Per 15 Minutes--Rate 2--Agency	Per 15 minutes	20	400.00	3.25	26000.00	
Group Respite Per 15 Minutes--Rate 3--Agency	Per 15 minutes	25	400.00	4.52	45200.00	
Supported Employment Total:						4388097.02
Individual Supported Employment	Per 15 minutes	53	1409.00	15.42	1151519.34	
Group Supported Employment LON Level 1	Per 15 minutes	21	4860.00	2.21	225552.60	
Group Supported Employment LON Level 2	Per 15 minutes	28	4860.00	2.96	402796.80	
Group Supported Employment LON Level 3	Per 15 minutes	19	4860.00	3.69	340734.60	
Group Supported Employment LON Level 4	Per 15 minutes	11	4860.00	4.06	217047.60	
Group Supported Employment LON Level 5	Per 15 minutes	16	4860.00	4.44	345254.40	
Group Supported Employment LON Level 6	Per 15 minutes	4	4860.00	4.81	93506.40	
Group Supported Employment LON Level 1	Per Diem	21	202.00	53.21	225716.82	
Group Supported Employment LON Level 2	Per Diem	28	202.00	70.96	401349.76	
Group Supported Employment LON Level 3	Per Diem	19	202.00	88.69	340392.22	
Group Supported Employment LON Level 4	Per Diem	11	202.00	97.56	216778.32	
Group Supported Employment LON Level 5	Per Diem	16	202.00	103.43	334285.76	
Group Supported Employment LON Level 6	Per Diem	4	202.00	115.30	93162.40	
Independent Support Broker Total:						23461.36
Independent Support Broker	Per 15 Minutes	8	221.00	13.27	23461.36	
Behavioral Support Services Total:						343764.00
Behavioral Support Services	Per 15 minutes	90	120.00	31.83	343764.00	
Individual Goods and Services Total:						12730.80
Individual Goods and Services	Per Service	20	6.00	106.09	12730.80	
Individualized Day Support Total:						420089.40
Agency Rate	Per 15 minutes	12	2732.00	8.54	279975.36	
Individual Rate	Per 15 minutes	6	3938.00	5.93	140114.04	
Interpreter Total:						19529.28
Interpreter--Language	Per 15 minutes	9	96.00	19.89	17184.96	

Interpreter--American Sign Language	Per 15 minutes	2	96.00	12.21	2344.32	
Specialized Medical Equipment and Supplies Total:						5834.95
Specialized Medical Equipment and Supplies	Per Service	11	1.00	530.45	5834.95	
Transportation Total:						81761.52
Per mile--Agency	Per mile	21	2020.00	0.92	39026.40	
Per trip	Per Trip	3	202.00	31.52	19101.12	
Wheelchair per mile	Per mile	4	2020.00	1.80	14544.00	
Per mile--Individual	Per mile	10	2020.00	0.45	9090.00	
GRAND TOTAL:					8587555.35	
Total Estimated Unduplicated Participants:					400	
Factor D (Divide total by number of participants):					21468.89	
Average Length of Stay on the Waiver:					356	

